BOLETIM
DO
SANATÓRIO SÃO LUCAS

FUNDAÇÃO PARA O PROGRESSO DA CIRURGIA

Rua Pirapitinguí, 80 — São Paulo, Brasil

VOL. XXII | MARÇO DE 1961 | N.º 9

Sumário:

Boletim do Sanatório São Lucas

Suplemento de

"ANAIS PAULISTAS DE MEDICINA E CIRURGIA"

Editado sob a direção do

DR. CLODOMIRO PEREIRA DA SILVA

pelo

SANATÓRIO SÃO LUCAS

FUNDAÇÃO PARA O PROGRESSO DA CIRURGIA

Diretor

DR. EURICO BRANCO RIBEIRO

Órgão oficial da Sociedade Médica São Lucas

Rua Pirapitinguí, 80, Caixa Postal, 1574 — São Paulo, Brasil

BOLETIM
DO
SANATÓRIO SÃO LUCAS
FUNDAÇÃO PARA O PROGRESSO DA CIRURGIA

VOL. XXII MARÇO DE 1961 N.º 9

Tumor peri-renal(*)

(Metastases de neo de estômago)

Prof. CARMO LORDY
(Anatomopatologista do Sanatório São Lucas)

Dr. WALDEMAR MACHADO
(Chefe da Secção de Maternidade do Sanatório São Lucas)

O caso que apresentamos nesta reunião tem interêsse dado os seus comemorativos senão vejamos:

J. D. P., de 56 anos, casado, branco, brasileiro, lustrador, foi por nós operado neste Sanatório por ser portador de dupla úlcera duodenal estenosante, sofrendo uma gastroduodenectomia parcial à Polya em 31 de maio de 1952. A ficha operatória revela dificuldades no isolamento e libertação do duodeno devido às aderências firmes. A peça operatória medindo 26 × 14 cm apresentava duas úlceras circulares profundas na parede anterior e posterior, tendo esta um centímetro de diâmetro e aquela 0,6 cm. O seu posoperatório foi normal, sem complicações, tendo tido alta no 6.º dia. Os exames preoperatórios feitos na ocasião nada revelaram de anormal. Não foi feito o exame anatomopatológico.

Em 14 de novembro do ano corrente o paciente procurou-nos novamente queixando-se de dores freqüentes sem ritmo e cada vez mais fortes no hipocôndrio e flanco direitos, sintomas êstes surgidos há três meses logo após uma pancada que sofrera na região lombar durante seu trabalho; emagreceu vários quilos (em julho de 1952, 67,100 kg; no momento 63 kg); queixa-se de soluço e nervosismo. Trouxe uma chapa radiográfica da coluna lombo-sacra que revelava espondilo artrite mais sacralização bilateral. O exame físico mostra o fígado aumentado de volume de superfície lisa com a borda a três dedos transverso abaixo da reborba costal, despertando dor à compressão. P. A. 110 × 70; panículo adiposo reduzido, pele sêca.

Foi feito o diagnóstico de provável neoplasia hepática. Foi pedido um colecistograma feito com telepaque, 12 comprimidos,

(*) Caso apresentado à reunião do Corpo Médico do Sanatório São Lucas em 24-11-60.

sendo negativo. Por orientação do radiologista foi pedida nova chapa radiográfica com biligrafina e com resultado idêntico. Nos 5 dias de internação préoperatória, reexaminado o doente mostrava apenas o mesmo quadro inicial com macicez contínua desde o rebordo costal até ao limite inferior da provável tumoração hepática, a par das dores persistentes. No dia 19 de novembro foi levado à mesa cirúrgica com o diagnóstico de neo do fígado; após antissepsia e preparo dos campos foi feita a incisão paramediana transretal direita abrindo-se até ao peritôneo, não se encontrando aderências à parede; o fígado e a vesícula, contrariando o diagnóstico, apresentavam o aspecto normal; duodeno e estômago também normais entretanto, apresentava-se um grande tumor retroperitoneal deslocando o fígado para a frente unido ao polo superior do rim direito deslocando êste para baixo. Amplia-se a incisão com outra acompanhando o rebordo costal, formando um v invertido, abre se o peritôneo retroperitoneal e consegue-se atingir os limites superiores do tumor que vão à coluna e até ao diafragma na linha mediana êle passa sob a veia cava constituindo nódulo de 3 cm, mais ou menos à esquerda da coluna sob o duodeno. Consegue-se luxar o tumor com o rim direito, libertação do tumor da veia cava: neste momento quatro centímetros acima desta zona de libertação houve dupla rotura da veia cava na parede anterior, levando o paciente ao estado de choque; com transfusões eleva-se a pressão arterial, colocando-se clampes de Satinski pelo Dr. Moacyr Boscardin que neste momento entrara no campo para fazer a cirurgia vascular, sendo pelo mesmo suturada a cava, pontos separados, fio de algodão montado 000. Continua-se a intervenção praticando-se a nefrectomia direita. Ao fazer-se a revisão da hemostasia surge nova rotura na veia cava, conseguindo-se também suturá-la. Dado o estado do paciente e a localização do nódulo já referido sob a cava e o duodeno não se tentou extirpá-lo, nesta altura o paciente já havia tomado 6 litros de sangue. Sutura do peritôneo posterior. Contrabertura do flanco direito para drenagem com dreno 18; fechamento da parede por planos; algodão na pele e penicilina em pó.

O tumor apresentava superfície irregular, endurecido, pesando 1.100 gr. O posoperatório foi silencioso, sendo retirado o dreno e pontos no quinto dia e tendo alta no oitavo dia em boas condições.

Passamos a palavra ao Prof. Carmo Lordy que nos vai falar sôbre as características do tumor.

Prof. Carmo Lordy. — A verificação do desenvolvimento insólito de típico carcinoma gelatinoso no território da suprerrenal justifica a indagação que se fêz, a saber, se o tumor em estudo é primário ou secundário e, nesta última hipótese, qual o órgão que lhe deu origem e qual a via percorrida por seus elementos.

No histórico do paciente, que acaba de ser relatado, ressalta a notificação de uma intervenção cirúrgica, praticada em 1952, por úlcera duodenal, de natureza infelizmente não esclarecida, por falta

do respectivo exame histopatológico. Não obstante, dessa simples referência foi possível coligir alguns dados de não pequeno interêsse para o caso em apreço. Com efeito, o que no exame predomina é o quadro histológico de intensa fibrose, reativa frente à infiltração de elementos epiteliais, dispostos em acúmulos e sob forma de cordões muito irregulares. Êsses elementos, de natureza carcinomatosa, apresentam-se com aspecto variado. Entre êles, alguns reproduzem o formato das assim chamadas células em sinete, isto é, células volumosas, claras, intumescidas pela degeneração mucosa de seu citoplasma e com núcleo em forma de crescente, recalcado para a periferia celular.

O conjunto relembra o quadro do carcinoma gelatinoso e esquirroso da parede gástrica. É grande a analogia dêste tumor com o de Krukenberg, considerado lá pelo passado qual um tumor primário do ovário (fibrosarcoma mucocelular carcinomatóide, na definição de Krukenberg); hoje atribuído à metastase de um carcinoma gelatinoso, principalmente do estômago. A analogia entre ambos faz-se com muita probabilidade também sentir no que diz respeito à via de propagação. No tumor de Krukenberg, às vêzes duplo desde o início, um em cada ovário, a propagação se efetua, na opinião da maioria dos A.A., através dos vasos linfáticos por via retrógrada. É lícito admitir-se que o mesmo processo se realize também no tumor da região suprarrenal.

Procurando relacionar entre si êsses diversos dados, pode-se concluir que o carcinoma gelatinoso insòlitamente desenvolvido no território da suprarrenal é um tumor secundário, metastástico, derivado, com muita probabilidade, de um tumor da mesma natureza, primário, localizado na região duodenal.

A úlcera duodenal, assinalada no relatório, talvez corresponda à ulceração secundária (não infreqüente em tais casos) de um carcinoma em plena fase evolutiva.

De acôrdo com a opinião documentada de Ribbert, o carcinoma inicia seu desenvolvimento ao nível da submucosa gástrica, para daí propagar-se através dos vasos linfáticos regionais, não só em profundidade, como principalmente em extensão superficial para a mucosa, que assim subminada desde o comêço não tarda em se ulcerar num ou mais pontos, às vêzes à distância um do outro.

Uma vez na luz dos vasos linfáticos, fàcilmente compreende-se a propagação dos elementos carcinomatosos por via direta ou por via retrógrada, como no caso em estudo.

COMENTÁRIOS

Dr. Carlos de Oliveira Bastos. — As tumorações do tipo da descrita levam, não raro, a erros de interpretação diagnóstica, atribuindo-se ao fígado a tumoração, quando na verdade ela é extra-hepática. Não é êste o primeiro caso, aqui no Hospital, em que

eu mesmo incidí, à primeira vista, nesta imprecisão de diagnóstico, pois tumores renais ou suprarrenais direitos podem, em seu desenvolvimento, decalcar o fígado, fazendo-o bascular para a frente, dando a falsa impressão de um tumor hepático.

A atribuição da metástase ao processo gástrico, tido na ocasião como ulcerativo péptico, deixa forçosamente uma dúvida significativa, dado o longo tempo decorrido entre aquela operação e o quadro atual.

Ressalta o Prof. Lordy a grande semelhança entre êste tumor de tipo gelatinoso e o tumor de Krukenberg. É interessante esta observação, favorável à natureza metastática do achado atual. Contudo, o caso deixa certas dúvidas de interpretação, conquanto de inegável interêsse clínico.

Dr. Eurico Branco Ribeiro. — Pelo exame das radiografias não nos parece que se trate de úlcera do duodeno e sim de úlcera gástrica próximo do piloro. É difícil, às vêzes, a localização exata de um processo ulceroso quando há uma infiltração maior de tecidos das vizinhanças; as úlceras próximas do piloro, tanto do lado gástrico como do lado duodenal, podem, perfeitamente, se confundir a um exame externo da peça.

É fácil verificar-se, recorrendo à literatura antiga, que os cirurgiões, principalmente os europeus, consideravam como de estômago as úlceras duodenais. Nas estatísticas que êles apresentavam, eram muito mais numerosos os casos de úlcera de estômago do que os de úlcera do duodeno; entretanto, está assente hoje, em todo o mundo que, as úlceras duodenais são muito mais freqüentes que as úlceras gástricas; daí se conclui que a verificação da sede da lesão não era exata nas primitivas estatísticas.

Sabemos que na úlcera duodenal é uma raridade o aparecimento de neoplasias malignas, enquanto que no estômago, principalmente na região do antro, elas são muito mais freqüentes, de sorte que, no caso presente, é muito provável ter-se assestado numa úlcera gástrica o início de um processo tumoral que tivesse dado a propagação ora encontrada.

Quanto ao tempo retardado do aparecimento de metástases, que não é normal, lembramos casos de nossa experiência que apresentam metástases a longa distância. Referimos aqui, recentemente, um caso de hipernefroma do rim operado em Viena 13 ou 15 anos antes de termos encontrado suas metástases na tireóide. Outro caso que recordamos é o de uma portadora de câncer do antro gástrico, da clínica do Dr. Eduardo Monteiro, que, naquela época — 1931-32 — foi dado como inoperável, tal o tamanho do tumor ao exame somático. Entretanto, conseguimos fazer uma gastrectomia com resultados aparentemente muito bons. Oito anos depois, essa enfêrma veio a falecer com um tumor do hipocôndrio direito. Êste caso é semelhante ao que o Dr. Waldemar nos apresenta hoje.

Gastric resection in conditions other than ulcer and cancer (*)

Dr. Eurico Branco Ribeiro
Diretor do Sanatório São Lucas

Nowadays, gastric surgery means primarily the gastric resection, since other types of gastric surgery have been either discontinued or utilized in specific rare cases only. Even the gastroenterostomy, very popular 30 years ago, has been abandoned in the main medical centers. In fact, the gastrectomy already took over its last indication, namely the acute perfuration in open peritoneum, in which case the gastroenterostomy was used combined with the simple suture of the opening found. Further, the establishment of the gastroenterostomy as a necessary complementary surgical operation of the vagotomy became a failure and is being a disapointment to its supporters. In fact, this operation has already surpassed that phase of popularity peculiar to new methods supported by well reputed surgeons.

Based on our 25 years' experience in surgery of the stomach, this paper will deal primarily with other indications for gastric resection than cancer and ulcers, although we recognise the latter as the two main indications for gastric surgery. In this period we had the opportunity to perform personally more than 2200 gastric resections as follows:

a) ulcers	1.846
b) cancer	184
c) others	181
	2.211

(*) Read before the meeting of the International College of Surgeons, September 9-13, 1956.

DISTRIBUTION OF THE 181 CASES OF GASTRIC RESECTION OUT OF ULCER AND CANCER

Gastric benign tumors		4
Neurofibromata	1	
Fibroma	1	
Aberrant pancreas	1	
Intestinal metaplasy	1	
Ringlike hypertrophy of the muscular sistem of the pyloric antrum		33
Dolicogastria and ptosis		67
Gastrites		57
simple gastritis	23	
ulcerativ gastritis	28	
hemorrhagic gastritis	3	
polypous gastritis	2	
mamelonous gastritis	1	
Pyloric conditions		4
Prepyloric stenosis	2	
Achalasia of pylorus	1	
Mucous protusion into duodenum	1	
"Ulcus sine ulcus"		2
Duodenal conditions		14
Diverticulum	11	
Periduodenitis	2	
Constrictiv duodenitis	1	
TOTAL		181

The gastric resection is generally employed in cases of stomach benign tumors and of metaplasic formations such as the aberrant pancreas. In such cases, the logical approach would be the simple removal of the tumor after gastrotomy. However, it is very difficult to ascertain beforehand the benign nature of the gastric tumors. X-ray, as a rule, does not reveal the nature of the tumor, and even in cases where a polipus is indicated, there is also the possibility of malignancy. Further, the patient's complaints, which imposed the X-ray examination, as a rule justifies in itself a radical operation. The microscopic diagnosis of cytologic elements obtained through Levin's tube from the stomach can only be conclusive when revealing typical cancerous cells. The negative examinations does not justify a conservative approach, and the same can be said of the biopsy and cogelation during the operation.

The gastroscopy is a propedeutic method of limited use, not very well liked by patients, and doubtfull as to its soundness since

It does not give the assurance the clinic would expect from a direct viewing method!

For these reasons benign tumors are taken care of by gastric resection, and surgeons are in full agreement on that.

*
* *

Another condition eventually requiring the resection is the pain produced by the so called ulcerous gastritis. It could be said that the ulcerous gastritis is no more than the multiple ulcers of the stomach. As a whole, it could be that, but the problem is a different one when analysed under the clinic and therapeutic point of views. The symptomatology of the ulcerous gastritis does not recede easily as the stomach and duodenum ulcers recede in face of adequate therapeutics and dietetics.

The patient starts is route through the physician's parlours, obtaining no more than quickly fading improvements. In almost all cases the symptomatology is that of the ulcers. The semiological tests developped towards the neighbouring organs (liver, pancreas, intestines, kidneys) are completely negatives and the symptomatology is typical gastric. Due to the failure of the various clinic treatments, the only solution is then a surgical operation, which will necessarily be the gastric resection, preceded by a verifying gastrotomy, in case the previous gastroscopy had not yet confirmed the diagnosis.

In some instances, a classic symptomatology of ulcers, with all examinations negative, including the surgical verifications turns out to be nothing not even a gastritis. Facing the problem of classifying the case within the known contingencies of the gastric pathology, certain authors, mainly spanish authors, developed the odd denomination "ulcus since ulcus", making use of the old fashioned latin to overcome the reality of ignorance. Their firm advice, once the clinic diagnosis is established, in face of a typical story, the patient can only get over through a gastric resection.

*
* *

From the absence of anatomo-pathologic signs of the gastric segment lets consider the recognisable alterations such as those consequent from inflammatory process. Gastritis are common cases. In general they obey to the medical treatment. Sometimes, however, they grow bigger and reach points of no retrieve, such as the

hypertrophic gastritis, the polypoid gastritis, and the "état mammelonee". It is difficult, sometimes, to obtain the definite step back of the symptoms and the clinic may be forced to transfer his patient to a surgeon. In this case the gastric resection is the adequate solution, as it is accepted by Eirian Williams.

Sometimes, the gastric mucosa does not suffer any sizeable inflammatory alterations, but hypertrophiates in the antral region, spreads over the muscles and crosses the pyloric ring. It is easy to foresee the inconveniences, sometimes intense, which may arise from this condition. The consequent morbid status has been denominated as prolapsus of gastric mucosa into duodenum. This is a new morbid status recently introduced in the gastric pathology. Its X-ray signs have been already described and among specialists its acceptance remains beyond any doubt. Not always the medical treatment is efficient and patients will go after a surgeon for a healing resection. It could be tried the simple removal of the overgrown mucosa adjusting the remaining to the dimension of its supporting muscles. This method, however, would call for a major disclosure of the gastric wall, with possible compromise of irrigation, and expansion of undesirable scars. The safest method, under our present knowledge on the subject, is the gastric resection.

* * *

The problem of the acute erosions determining hemorrages sometimes attaining great volume is another case in which the resection is advisable. The surgeon finds the intestine and the stomach full of blood and cannot perceive any signs of an ulcerous lesion in its walls. The gastrotomy rarely helps him in the research of the bleeding point. He has to decide for a gastrectomy. And sometimes he finds in the extirpated piece as a cause for the hemorrage, a vessel gaping or covered by a small clot at the botton of an indetained ulcer or a simple erosion. If nothing of the sort is found he decides for a panel hemorrage, but, even not having discovered the cause of the bleeding he saved the patient's life thanks to the resection.

Cooper and Ferguson, of Philadelphia, published a study encouraging he resectionist behaviour in the hemorrages from indetermined causes from the higher portion of the gastro-intestinal tube. The abstention of the so called "blind gastrectomy" in one of the patients caused his death and the autopsy showed that it was a lesion passive of resection.

Harry Bockus presented at the Congress of the American Medical Association, in Atlantic City, in 9 June 1955 the case of a patient, already operated on for cancer of the ascendent colons who suffered

from several hematemesis and melenas in the post operatory period receiving 61 blood transfusions in 35 days of hard struggle between life and death. The autopsy only demonstrated erosion of the stomach. A gastric resection would have saved this patient.

* * *

Affecting both interior layers of the stomach there is a rare affection that might demand a gastric resection — the scary estenosis by caustics, as advised by Bosch del Marco in 1946. The same applies to the prepyloric estenosis consequence of an ulcerous scar. Conveyed from the mucous to the muscular layer of the stomach two pathological conditions shall be found — one, the distension and atony of the walls: the other the hypertrophy of the muscular system.

The first is named adequately or not of gastroptosis, dolicogastria, megaestomach atony, or better gastric hypotony. It is a condition that might bring rather serious consequences to its sufferer: the stomach does not empty itself in normal time, keeping partially the intake of food being transformed in a focus of intoxicating fermentation with decisive repercussion on the nervous system. The use of an apropriate girdle, an adequate diet, a moderate way of living, and a suitable medication very often succeed to attenuate and even eliminate the suffering that the condition causes. There are many cases though, when all these means fail and the patient lives through the agony of trying to empty his stomach or even recurs to the expedient of vomiting to have a few hours of relief. In these cases the gastric resection is strongly advisable. In many cases the results are excellent; in others, though, the consequenses on the general state of health and specially on the nervous system are so serious that a long time will be needed to apreciate the real good effects of the intervention. And still there are some cases when the patient will even need the orientation of a psychiatrist.

* * *

The hypertrophy of the gastric muscular system is another condition that might impose a resection. It is well known the so called hypertrophic stenosis of the pylorus of the newborn, but its cure although surgical, generally is obtained by the simple section of the muscular fibers as traught by Rammstedt — Fredet. The sauce does not apply though, to the cases of the hypertrophic stenosis of the pylorus of the adult — when a gastric ressection is needed.

The denomination by which is Kowan this morbid state that many authors seem to identify with that of the child and to many it seems an entity by itself did not satisfy those who wish to give to the denomination a rational sense. Neither does the expression — achalasia — lack of relaxing, that is permanent hypertony as this word would be applicable only to the esphincteres. Well the muscular hyperthrophy, in the discussed disease is not caused by the muscle of the opening of the pylorus. It is caused by the fibers that sorround and restrict the gastric region denominated "antro pilórico". That is why in 1934 we propose to this morbid state the name of "ring like hypertrophy of the muscular system of the pyloric antrum", designation perharps a little long but very clearly expressive since the hyperthrophy is shown along all the extension of the muscular fibers of the pyloric antrum of the stomach.

This condition causes a permanent narrowing of light of the last portion of the stomach, that stays very rigid in the X-ray examination the wall of the antrum being mistaken for the esphincter of the pylorus which is projected in prolapsus inside the duodenal cavity. The X- ray peculiar image is known as the sign of Kirklin.

The tumour formed by the ring like hypertrophy of the muscular system of the pyloric antrum simulates a cancerous lesion under the X-ray examination and even at the operatory table under the surgeon's eyes. Sometimes there is the occurrence of both diseases, as recently we had the opportunity to verify. At the Mayo Clinic there was once also a case of cancer and hypertrophy. It is more commun, though to find the ulcer in these cases and Kirklin and Harris demonstrated this ocurrence in 29 of 81 cases of ring like hypertrophy. The lesion pure and simple whitout any other association was found in 31 of these 81 cases registered at the Mayo Clinic.

Our experience has shown simple cases but the association is more frequent, specially with the ulcer, either in the same place of the hypertrophy or at a distance as in the case which documentation we shall expose we found 11 cases of pure hypertrophy in 33 cases.

The ringlike hypertrophy of the muscular system of the pyloric antrum is irreversible, The solution is surgery which is obtained by a gastric resection.

* * *

Outside the gastric pathology we still find opportunities for gastric resection. We refer to two specific contingences: the diverticulum of the duodenum and the digestive sequels of the cholecystectomy.

In these two cases although it may seem very strange that the gastrectomy can be advisable.

The diverticulum of the duodenum is an anomaly that may be found very communly. It can produce clinic symptoms sometimes very acute, even besides the diverticulitis and the perforation. It is a focus of retention of food favoring harmful fermentations. We never had the opportunity to find a diverticulitis of the duodenum, although the symptomatology of the patients was copious. Once we did find inside as diverticulum of the 4th portion of the duodenum and nowhere else, a good portion of the baryo taken days before for X-ray examination. Some authors considerer the case as surgical every time the X-ray image obtained by a contrast substance persists for more than 12 hours. Our experience taught us that the simple removal of the diverticulum, following the advice of the classic authors, generally does not clear the clinic case: the patients continue to complain and present very often symptoms similar to those of the duodenum ulcer. And also the removal of one diverticulum of the second portion assested generally by the side of the Vater's ampulla offers certain technical difficulties and is not free of risks. But it was mainly the clinic failure of the diverticulectomy that lead us to try, in those cases, the derivation of the food transit by means of the gastric resection by Polya's method. We obtained with this a completely satisfactory result. And we rejoiced to verify that also some of the modern authors adopted identical orientation after having observed certainly the same unsatisfactory results. John Waugh and Edward Johnston verified in Rochester that only less than half the patients obtained the expected results with diverticulectomy. The gastroenterostomy, once atempted by the same authors, failed to meet its purpose. Only the gastric resection has so far given to the sufferers from the duodenal diverticulum. For all this the subtotal gastrectomy has been used by Lockwood, Fulder and others. Richard Cattell and Thomas Mudge made the gastric resection in a case of diverticulitis.

Supported by the opinion of these authors, we feel free to continue to recommend the simple gastrectomy that we had already employed for the treatment of the symptomatic diverticulum of the duodenum, leaving it without being manipulated.

We still have to consider the indication defended by Arnaldo Yodice on the IV Pan American Congress of Gastroenterology held in S. Paulo in 1954. This Argentinian author presented the first results of the behaviour he has recently adopted in the cases of the digestives sequels of the cholecystectomy. They were patients who were submitted to the extraction of a gall-bladder with stones

or, more frequently, a gall-bladder prone to chronic inflammation and who continued to suffer from chronic indigestion, pains in the right hypochondrium, migraines, hyperchlorhydria, vomits, etc. The X-ray examination does not detain anything in the stomach, there is no lithiasis in the choledocum, the papillotomy was atempted to overcome the billious dyscinesia. The gastric resection clears the case in Yodice's opinion. It is, no doubt, an audacious indication for gastrectomy. Time will tell us of its appropriateness. The enthusiasm of just one author is not sufficient to recommend a method. It is necessary to have it pass through the sieve of many an observing mind to deserve consagration. The future will tell us about its merit. For the moment let us limit ourselves to register the opinion of a surgeon of prestige who deserves great consideration.

* * *

Resuming, the gastric resection may be strongly advised, even out of cases of ulcer and cancer. The ulcerative gastritis and the hemorrages by erosion offer a ground of transition between the ulcer and other affections not tumorous of the stomach and also as the polypous gastritis and the mamelonous gastritis offer grounds of transition between the cancer and the benign tumours of the stomach. The cicatricial stenosis of the pyloric antrum by caustics are a rare indication for gastric resection. Not only do they attain the mucous stratum but also affect the muscular stratum in which other lesions will be detained the ringlike hypertrophy meaning hypertrophy in which as well as in extention — that is translated as gastric ptosis.

Outside the stomach we will find two seldom used indications for gastrectomy the diverticulum of the duodenum and the digestive sequels of the cholecystectomy. To this can be added the resection by invisible lesion — the "ulcus sine ulcus" of the Spaniards. Other indications may be found. But it was about the cases shown above that we had the great pleasure and privilege to report for this splendid auditory. Thank you very much for your kind attention.

BIBLIOGRAFIA

ARNALDO YODICE — *Gastrectomia* — Rev. Gastroenterologica Brasileira, VII, 181, July-August, 1955.

COOPER & FERGUSON — *Gastric resection for upper gastrointestinal hemorrhage of undetermined cause* — J. Am. Med. Ass., CLI, 879, March 14, 1953.

DIEGO ZAVALETA, PEDRO BOLO & ALFREDO GORE — *Relación entre gastritis hipertrófica y cancer de estómago* — Prensa Médica Argentina, XLIII, 802, March 9, 1956.

EIRIAN WILLIMS — *Giant Hypertrophic gastritis* — The Lancet. CCLXX, 363, April 7, 1956.

FAIRFIELD GOODALL e RONALD C. SNIFFEN — *Mucosal hypertrophy of the stomach* — The New England Journal of Medicine, CCXLIX, December 31, 1953.

JOHN WAUGH & EDWARD JOHNSTON — Collected Papers of the Mayo Clinic, LVI, 74, 1954.

KIRKLIN & HARRIS — *Hipertrophy of the pyloric muscle of adults; a distinctive roentgenologyc sign* — The American Journal of Roentgenology and Radiumtherapy, XXIX, 437, April, 1953.

LOUIS BOSCH DEL MARCO — *Contribuición al estudio de la gastritis corrosiva* — An. Fac. Med. Montevideo, XXXIV, 891, 1949.

STAMMERS (F. A.) — *Nerver surgical approach to carcinoma of the stomach* — Proceedings of the Royal Society of Medicine, XLII, 659, September, 1949.

W. D. PARK — *Giant hypertrophic gastritis* — The Lancet, CCLXX, 751, May 19, 1956.

O Sanatório São Lucas em 1960

Movimento do Ambulatório

Dr. João Noel von Sonnleithner
Chefe de Serviço do Sanatório São Lucas

MESES	CURATIVOS	EXAMES	ONDAS CURTAS	INFRA-VERMELHOS	ULTRA-SOM	INJEÇÕES	IMOBILIZAÇÕES
Janeiro....							
Fevereiro .	234	2	22	—	51	9	—
Março ...	206	4	3	1	16	3	1
Abril.....	126	2	9	—	40	1	1
Maio.....	142	—	8	1	9	3	3
Junho.....	125	4	6	—	11	3	2
Julho	225	8	3	1	18	5	15
Agosto....	119	—	6	—	18	4	9
Setembro .	191	—	—	—	5	2	8
Outubro...	186	1	1	—	4	—	4
Novembro	155	—	3	—	15	4	2
Dezembro .	209	—	—	—	6	8	3
Total..	1.918	21	61	3	193	42	48